DOCUMENT RESUME

ED 467 397 RC 023 642

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TITLE	Androgogy and Aboriginal Australian Learning Styles.
PUB DATE	1999-07-00
NOTE	16p.; In: Indigenous Education around the World: Workshop Papers from the World Indigenous People's Conference: Education (Albuquerque, New Mexico, June 15-22, 1996); see RC 023 640.
PUB TYPE	Reports - Descriptive (141) -- Speeches/Meeting Papers (150)
EDRS PRICE	EDRS Price MF01/PC01 Plus Postage.
DESCRIPTORS	Aboriginal Australians; *Allied Health Occupations Education; *Community Health Services; *Culturally Relevant Education; Foreign Countries; *Health Personnel; Higher Education; *Indigenous Personnel; Indigenous Populations; Nontraditional Education; Rural Education
IDENTIFIERS	Australia (New South Wales); *Learner Centered Instruction; University of Sydney (Australia)

ABSTRACT

This paper discusses the work of Yooroang Garang: the Centre for Indigenous Health Studies at the University of Sydney (Australia), focusing on professional education of Aboriginal health workers (AHWs). Aboriginal Education Centres in tertiary institutions are challenged to ensure that those institutions impart knowledge that is relevant and appropriate to Aboriginal people's cultural needs and aspirations. Most students at Yooroang Garang come from rural New South Wales, where the health status of Aboriginal people is much poorer than that of Whites. AHW training is critical to improving health conditions in rural Aboriginal communities, as AHWs deliver primary care services, provide health promotion and health education, and act as cultural brokers. However, AHWs encounter many problems: maintaining their own cultural identity; balancing Western and Aboriginal concepts of illness and health; and coping with isolation, confidentiality issues, gender issues, insufficient training, and lack of recognition by other health professionals. Yooroang Garang has developed culturally appropriate strategies to improve Aboriginal students' learning outcomes, including student attendance in 2-week study blocks; consideration of Aboriginal attitudes toward kin, community, and land; structured kits of learning materials to support indigenous adults undertaking off-campus study; supervised cooperative projects in Aboriginal communities; and teaching methods that build on learners' experience, enable students to assess their own learning needs, and are appropriate to the learning styles of Aboriginal adults. (SV)

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ANDROGOGY AND ABORIGINAL AUSTRALIAN LEARNING STYLES

Yooroang Garang: The Centre for Indigenous Health Studies, University of Sydney

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Androgogy and Aboriginal Australian Learning Styles

Paper delivered at

1996 World Indigenous Peoples Conference: Education

Albuquerque, New Mexico, USA

Presented by:
Kathleen Clapham. Angela Dawson, Patricia King, Leslie Bursill

Yooroang Garang: The Centre for Indigenous Health Studies, The University of Sydney

Introduction

The major factor retarding the development of education in Australia is the history of exclusion of Aboriginal people from the educational and the inappropriate nature of many educational services to Aboriginal needs and aspirations. Because of these factors Indigenous people have been denied the educational outcomes demanded by the range of government reports, policies and studies undertaken over the past decades[1] One of the most recent of these Australian reports. the 1994 Review of the National Aboriginal Education Policy, reveals that although we now see more Aboriginal and Torres Strait Islander students are coming into higher education institutions:

> Universities and other tertiary institutions are **not retaining** indigenous students
>
> Indigenous students continue to **experience difficulties** with university courses.

In particular in the area of the health sciences, research undertaken by the University of Sydney clearly shows that:

> Indigenous people encounter serious difficulties in **applying university-based knowledge** to indigenous health issues.

In this paper we would like to address a major challenge facing Aboriginal Education Centres which are located within tertiary institutions at the present time: the challenge of not only making tertiary education **accessible** to indigenous people and producing indigenous graduates skilled in a broad range of areas but also ensuring **that the knowledge imparted by those institutions is relevant and appropriate to the particular cultural needs and aspirations of Aboriginal people:** that it facilitates the process of real self-determination not just reliance on government handouts, for Aboriginal

communities; that it leads to direct and immediate improvements in health and living conditions.

In addition we wish to acknowledge the valuable points of view put forward by others at this conference, in their discussions of indigenous higher education. In particular, Vera Kirkness has raised our awareness of the importance of grappling with issues such as:

students being expected to leave their "cultural bundles" at the gate of the university, a predominantly WASP urban male educational system

the importance of recognising, and demanding respect for, indigenous knowledge

being able to build on this knowledge as a basis for university education

problems of admitting students to universities, funding, accreditation

problems of racism and students rights

We can only say' that these issues are as important for us in Sydney, Australia as they are in British Colombia, Fairbanks. New Mexico and the many other places people have come from for this conference.

In this paper we will be focusing on the work currently being undertaken by our Centre. particularly in the area of professional education of Aboriginal Health Workers in Australia. We are also particularly interested in learning about the strategies and practices in the area of indigenous health and health education which have emerged elsewhere, including North America. New Zealand and Hawaii. A major objective of the work we are currently undertaking is to acknowledge indigenous knowledge, including health knowledge and healing practices, which is so often omitted from tertiary education courses.

Yooroang Garang

Yooroang Garang means ~strong place' in the Dharug language. Yooroang Garang: The Centre for Indigenous Health Studies is located within the Faculty of Health Science at the University of Sydney. It is one of two Aboriginal Units within the University. Aboriginal students who study at the Faculty of Health Sciences are drawn from a wide range of areas throughout Australia, including the Torres Straits, Queensland and South Australia. Most of our students come from rural NSW.

Yooroang Garang provides two programs for Aboriginal people who wish to work in the area of Aboriginal Health and Community Development: the Diploma and Bachelor of Health Science (Aboriginal Health & Community Development). Aboriginal health worker programs were first set up in the early 1980's in conjunction with the NSW Dept of health. The 3 year Bachelor program was first offered in 1993. Students in these courses study 'core subjects: Primary health care; (including Drug and Alcohol studies and health promotion); Counselling; Communication skills; Perspectives in Indigenous health; Community Development and Field Experience; as well as a range of other subjects such as Biological and Behavioural Sciences, legal and ethical studies, epidemiology, health planning policy and research skills.

Like other Aboriginal Education Centres located in tertiary institutions Yooroang Garang has attempted over the years to specifically address the educational problems commonly experienced by Aboriginal students: lack of access to university education, poor attrition rates; learning difficulties; educational disadvantages at the primary and secondary levels. At the same time we have attempted to develop an **inclusive curriculum,** a curriculum which values, reinforces and strengthens the culture and identity of Aboriginal people.

One of the paradoxes of indi2enous tertiary education is expressed clearly in the following quote from a university graduate grappling with the difficult issue of maintaining Aboriginal culture while aspiring to higher education:

> 'Yeah, they say, 'there goes the white man's education, then you're not black any more. But you need that white man's education, like nursing, it didn't prepare me to work with my own people (and) I never learnt any thing about Aboriginal health. But I needed that theoretical base so that I could go and work for my people and say, 'Hey...all right This is the way they showed me but it doesn't suit our culture. I'm going to change it. I'm going to do it this way, this way is more appropriate.[2]

Before we go on to talk about one of the specific ways we are trying to do this we will provide a little more information about the Aboriginal Communities of New South Wales and the types of health and community development issues which they confront.

NSW Communities

There are currently around 260.000 Aboriginal people in Australia representing 1 .6% of the population. Around 66% of Aboriginals and Islanders in 1986 live in urban areas. This is the trend in all States but NT still has 69% of Aboriginals outside major towns.

Unlike the more remote parts of Australia, such as Northern Territory and Western Australia, where traditional communities were still intact until the 1930's, the indigenous people of New South Wales were the first to feel the

brutal force of British colonialism which began in 1788 .The history of genocide in New South Wales, the history of 'black raids' and poisoned water holes, the racism of the rural towns, policies of protection, assimilation and institutionalisation. the practices of the Welfare Protection Board, the removal of Aboriginal children and the destruction of Aboriginal families, like that of many other colonised nations, still forms part of the 'hidden history' of Australia. a history which is still too painful to be taught to school children the marvellous 'discoveries' of Captain Cook are far more palatable and most often ignored by the white population. This history of silence and denial still pervades the Aboriginal experience of white Australian society and impinges on their mental, physical and spiritual health on a day to day basis.

Aboriginal Health Status NSW

The health status of the Aboriginal people of NSW reflects the general pattern of disease and illhealth found throughout Australia. As with education, over the years we have seen a plethora of government and research reports condemning the state of Abori2inal health but to date Australian Aboriginal people are yet to reap substantial benefits from the politics of Abori2inal health One of the most influential reports of recent years has been the 1991 *Report of the Royal Commission into Aboriginal Deaths in Custody* ~ which stated that:

> 'By virtually every health measure, the health of Aboriginal and Torres Strait Islander people is worse than that of other Australians. The Royal Commission found a clear relationship between the continuing poor health status of Aboriginal and Torres Strait Islander people and their deaths in custody. This underlying disadvantage experienced by Aboriginal and Torres Strait Islander people is reflected in high rates of illness, self-destructive behaviour, crime and violence.

The two broad areas covered by the many recommendations of the Royal Commission were:

> more immediate life-style problems, particularly alcohol and substance abuse, which have a direct relationship with the incarceration of Aboriginal and Torres Strait Islander people; and
>
> longer tern problems associated with the underlying social disadvantage experienced by Aboriginal and Torres Strait Islander people, and evidenced by their poor health and reduced expectancies.

A major recommendation of the Royal Commission (271) was for the implementation of the 1989 National Aboriginal Health Strategy working party document f However, by late 1994 we saw a damning evaluation of the NAHS6 showing that five years after the publication of the Strategy, significant improvements in Aboriginal health had not occurred in Australia, in fact the report found

'minimal gains in the appalling state of Aboriginal health' (p.2)

The first major finding of the Evaluation committee was that the NAHS was never effectively implemented. The second was that it NAHS initiatives were grossly Underfunded by all governments. Anther was that pubic health providers need to create meaningful coalitions with Aboriginal and Torres Strait Islanders so that communities and individuals can make informed choices regarding health.

One outcome of this report was a shift of the Aboriginal health portfolio from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Health in the budget of May 1995. This took effect in July of this year. For many it was clear that ATSJC, the organisation which most represented Aboriginal self determination and self-management had become the scapegoat for the lack of political commitment to improvements in Aboriginal health by governments in all parts of Australia. Despite the common conception that governments have been throwing money at Aboriginal people, a recent parliamentary research paper 'Innovation without Change' documents the fact that there has not been significant increases in real terms in spending in Aboriginal health programs for more than 20 years (Murray 1995)7. To most it appeared quite clear. Aboriginal people and organisations are not capable of managing their own affairs.

One outcome of these major reports. if not huge improvements in health, has been a vastly improved collection of statistics which enables a better monitoring of the state of indigenous health.[8]

We will not go into details about the current health profile of Aboriginal people these have been well-studied. Suffice it to say that while there have been significant improvements in some aspects of ATSI health over the past two decades for example in:

Higher life expectancy

Reduced infant mortality

Reduced incidence of infectious and parasitic diseases particularly amongst infants and children

Comparing health statistics (hospitalisation rates: maternal mortality; disability'; high mortality) of Aboriginal and other Australians still reveals enormous discrepancies. It is impossible, however, to understand the health problems of Aboriginal people without referring to the history of black/white relations and the racist attempts to control Aboriginal people through policies of protection, assimilation and institutionalisation as We have mentioned

above. It is within this context, too that the role of the Aboriginal Health Worker has emerged.

Aboriginal Health Workers

Numerous recent reports including those mentioned emphasise the extremely important role of the Aboriginal health worker to the delivery of primary health care to Aboriginal communities. The NAHS recognised the training of Aboriginal health workers as integral to improving the health status of Aborigines. The importance of training Aboriginal Health Workers was also recognised by the Royal Commission into Aboriginal Deaths in Custody. One crucial factor in the appeal of these health workers is their close association with local Aboriginal communities: they are often regarded as acting as 'cultural translators' bridging traditional and western world views. Recent research has found however, that perceptions of health worker roles vary considerably particularly between non-Aboriginal health professionals who most often regard the cultural broker role as all important, to Aboriginal communities, who usually see the community care role of health workers as of the utmost importance[9].

The role of Aboriginal Health workers varies somewhat throughout Australia. In the Northern Territory, for example, clinical roles are more important as are traditional healing methods. In NSW health workers are commonly employed by Aboriginal controlled community organisations or by the NSW Govt as Aboriginal Health Education Officers, Aboriginal Liaison Officers eg. within hospitals, clinics) and their role is more focused on public health, health promotion and health education. Despite these different emphases, Aboriginal health workers share a great deal in common.

In the words of Barbara Flick (Indigenous Health Adviser, to the Australian Medical Association) in a recent article called 'Aboriginal Health Workers: Slaves or Miracle Workers"[10]:

> 'In addition to the purely clinical skills Aboriginal health workers deliver to our people. they are an integral part of the interface between whitefella medicine and whitefella medical workers and doctors...AHW are the backbone of primary health care services to our people.'

But while a great deal of emphasis has been placed on training Aboriginal people for health work, recent discussions with Aboriginal health workers and research carried out by the University of Sydney [11] reveals that numerous problems are encountered 'on the ground' by Aboriginal health workers which inhibit their ability to carry out the roles expected of them.

Some of these problems are of a **'cultural' nature.** They include: being able to maintain cultural identity when the trainee has to move away from his or her community to undertake training

Some problems relate to the **different models of health and illness of** indigenous and western cultures:

many have to learn new diagnostic health skills and new (medical) language skills (especially more traditionally oriented health workers)

they have to deal with both Western concepts of illness and health (based on disease within the individual body) and Aboriginal understandings of health which is more holistic and more esoteric, often uses social (racism), historical (alimentation from land) and cultural (supernatural forces) as explanations for illhealth

may rely largely on intuition which is not recognised as legitimate by other health professionals whereas traditional Aboriginal observational skills are acknowledged as valuable within the Aboriginal community.

for more traditionally oriented health workers their cultural knowledge is often completely ignored when it comes to health planning carried out by the 'experts' 'who fly in and out of our communities to tell us what they reckon is good for us' (Flick 1995:11).

Some problems lie with the nature of the **communities** they live in:

the isolation of health workers in remote and rural communities problems of violence in rural and urban communities;

poor understanding of health issues by management committees and employers;

problems of confidentiality within Aboriginal communities;

issues related to the gender of the health worker

But many of the problems are of an **industrial** nature such as:

short term employment through lack of ongoing funding for positions

lack of accreditation for the training they receive

lack of recognition of skills by other health care practitioners.

Again, as Barbara Flick so eloquently puts it:

> What these reports have also revealed is that Aboriginal Health Workers are absolutely at the bottom of the heap when it comes to recognition of their role in the primary health care system. The reports show that Aboriginal health workers - some of whom have served in the system for up to 20 years - work under appalling conditions in badly designed clinics; live in conditions that barely rate with the Third world; are underpaid and overworked...
>
> Most receptionists in doctors' surgeries receive higher wages than health workers of 10 to 20 years experience who are responsible for

immunising children, delivering clinical, carrying out health promotion. doing pap smears, taking blood, ensuring the airstrip is lit for the midnight RFDS evacuation etc etc'.

Despite the Recommendation 262 of the RCIADC about the need to establish appropriate career structures and registration for them. Aboriginal Health Workers commonly express the following problems:

Lack of training opportunities and courses which are appropriate to their needs. Many employed as Aboriginal health workers, In many Community controlled medical organisations Aboriginal health workers are employed with no specific training

Inability to undertake long term training courses (eg. 2-3 year Diploma courses) because of lack of academic preparation, too far from home (need to be away from home 10 weeks of the year), family commitments, community commitments

Inability or unwillingness of employer organisations to allow worker to undertake training course (can't release from work duties)

Lack of career structure

Isolated, no support or professional network set up. Has to be done by individuals

inappropriate duties demanded of them. Often used as 'taxi drivers' to transport people (a real need exists here) rather than being used to develop health promotion programs or counsel those in need

working for underfunded organisations. Little expertise or support for Aboriginal health workers

Lack of recognition and remunerations on completion of training courses

Resultant attitude amongst many employed as Aboriginal health workers that there is no point in training.

In a recent paper entitled 'Sickening bodies: how racism and essentialism feature in Aboriginal women's discourse about health', Mitchell's makes the following observations about the position in which Aboriginal health workers often find themselves:

'Urban people are just as concerned as those living a more traditional lifestyle in maintaining their culture, autonomy and self representation. Women see education as they key in the battle to better their life conditions but they are also aware of the conflict between their own system of values which placed family commitments first and one which

> priorities work commitments. Another major concern in this regard is whether by passing through mainstream educational institutions they will become 'assimilated; and somehow 'less Aboriginal' or 'white Aboriginal' (referred to as coconut). Aboriginal health workers, especially those working in Aboriginal Medical Services are especially vulnerable to such criticism from their own people."

This quote from a research project undertaken by the Faculty of Health Science on women's health in the Blacktown area of Western Sydney highlights some of the core issues underlying Aboriginal health and the provision of health services for Aboriginal people.

Aboriginal Health Workers and University Education

As We said earlier a range of culturally appropriate strategies for improving the learning outcomes of Indigenous students has already been developed by the Yooroang Garang (formerly the Aboriginal Education Unit) over the past decade including:

> innovative modes of course delivery. The AEU was a pioneer in the area of block-mode delivery in NSW. that is the students come to the college (mostly from rural New South Wales) for 2 week study blocks, 4 or 5 times durin2 the year.
>
> appropriate curriculum models and
>
> flexible methods of administration
>
> working towards overcoming the institutional barriers to access and participation

These are all imperative to meet the educational needs of Aboriginal people and are based on the understanding that educational programs for Aboriginal people must be organised and conducted in a manner which reinforces the values, beliefs and practices important to Aboriginal people and communities [5]Two fundamental factors which must be considered are:

> Aboriginal attitudes toward kin and community and
>
> the close relationship of Aboriginal people to the land.

both of which involve obligations, practices and beliefs not widely held in the broader Australian society.

Aboriginal health courses have been taught in block mode at Cumberland College for the past 10 years with successful outcomes for graduates and Aboriginal communities

Block-mode delivery specifically targets (a) students currently employed full time many as health workers (b) students from rural or isolated areas (c) students with family/kin obligations. Block mode allows students to remain as part of their communities, so that community involvement in the courses of study undertaken by Aboriginal students is maximised and the relevance of that study to the community is apparent.

Although block mode programs have had considerable success they have been limited by factors such as:

lack of academic and tutorial support for students When off campus

difficulties students face in accessing learning and resource materials in rural and remote areas

lack of access to information and computer technology in these areas, and

the perceived irrelevance of university based knowledge to problems at the community level.

During 1994-5 Yooroang Garang and the Koori Centre (in consultation with Aboriginal communities throughout Australia) undertook an extensive evaluation of the design and modes of delivery in courses offered to Indigenous students at the University with the aim of making courses more culturally appropriate. A number of specific learning strategies of indigenous adults were identified in this research[16] including: to the devastating health and education problems which beset our communities.

The growth of international conferences held in indigenous health and education (particularly WIPC:E and Healing our Spirit) reflect the growing mood of determination to improve indigenous health and education and in particular to search for culturally meaningful answers to community health problems. The 1993 World Indigenous Peoples Conference: Education, held in Wollongong in December 1993 carried the theme 'the answers are within us'. The Second Healing Our Spirit Worldwide Conference in Sydney, November 1994 gave emphasis to the spiritual dimension of the holistic health model required to overcome the problem of drug and alcohol addiction in indigenous communities. What has flowed from these important conferences is the need to seek answers to health and education problems from within indigenous communities and cultures. Without denying the importance of essential public health measures and the underlying social and economic causes of poor health in such communities, it is important to recognise the essential way in which self determination, empowerment and dignity feature in healing and maintaining community health..

Working With Communities

Yooroang Garang are currently developing a resource kit of learning materials to support independent learning by indigenous students or groups of students during the off-campus inter-block periods of block release programs for Aboriginal health professionals. This will make available a structured kit of learning materials for indigenous adults who undertake programs involving extensive periods of off-campus study. These learning materials will integrate key areas in the curriculum and will support students, in consultation with academic staff at the university, working in teams on problem-solving projects which are relevant to Aboriginal health and community development, for example, issues to do with alcohol and other drug use, domestic violence, diabetes, family planning, sexually transmitted diseases etc.

Supervised cooperative projects will engage students with local indigenous primary health care providers and other Aboriginal community members in practical activities which have a sound pedagogical basis. The problemsolving focus of these projects will empower students to become agents of change in their local communities. The resource kit will draws on the experiences and priorities of indigenous people and their communities, but a further outcome will be reciprocal learning for members of Aboriginal communities involved in student projects.

The project based on the following pedagogical principles:

students take part in the planning and conduct their own learning experiences

teaching methods build upon and make use of the experiences of the learners

students see the program as relevant as learning experiences are organised around real life problems and solutions, rather than simply studying selected topics

the problem-centred kit addresses special educational and health needs of Aboriginal communities

by responding directly to employment opportunities and the priorities of the major employers, a relevant and professional outcome will be met.

This type of course design is recognised as **an urgent and important priority** for improving access, participation and successful outcomes for indigenous people in higher education and meets particular recommendations of the Report of the Royal Commission into Aboriginal Deaths in Custody concerning culturally appropriate education.

The primary target group are Aboriginal students enrolled in the Diploma and Bachelor of Health Science (Aboriginal Health and Community

Development) programs. The resource kit will directly address the limitations of block mode courses, outlined above, by facilitating an exploration of the critical relationship between the course, the students and their communities. It will be based on a model of education (bi-cultural transformation and generative) in which students have an active and interactive relationship with the course of study, the staff, other students, their communities and workplaces. Courses will be re-designed so that major concepts introduced during block will be applied/practiced when the student returns to her/his community.

Students will be given opportunities to discuss and explore, in their own terms, problems and issues which arise in their communities. Community based tutors who currently work with the minimum of guidance and support from lecturers, will have a clear set of practical guidelines and exercises which embody the expectations and outcomes for each student.

It is important that the resources we develop take into account the learning styles of Aboriginal adult learners. Information must be presented in a variety of ways including audio-visual resource and students be given the time and space to take in and process information which is presented. Aboriginal terms of reference, values, beliefs must be respected. The resources must enable students to assess their own learning needs and give them a sense of independence and teach skills which they can develop further. The past learning experiences of Aboriginal students must be the basis for further development. The building up of self esteem is an important part of this process.

The resource kit of learning materials will integrate key areas of the curriculum, thereby combining theoretical and practical approaches and which are based on a series of supervised independent projects carried out by groups of students in their communities.

The learning materials we develop will enhance the effectiveness of the curriculum by providing a set of materials which integrate key areas of the curriculum so that rather than being confronted with a series of independently derived assessment items, students will be involved in working together with their co-students on an integrated problem based project which relates their university studies to problems and issues in their local communities.

Footnotes:

[1] DEFT (1989) National Aboriginal and Torres Strait Islander Education Policy: DEEr *(1990)A Fair Chance Jbr All;* The Report on the Royal Commission into Aboriginal Deaths in Custody (1986), Bin

[2] Sallik. M. (1989) *Aboriginal Tertiary Education in Australia: How well is it serving the needs of Aborigines:* Review of the National Aboriginal Education Policy (1994)

[2] Mitchell. D. (1994) ~5ickening bodies: how racism and essentialism feature in Abori2inal women's discourse about health. Paper Delivered at Australian Anthropological Society Annual Conference. Sydney.
NSW.

[3] Langton 1993:12: Mitchell [995 manuscript.

[4] 99 deaths investigated: 37 due to disease including 19 from pre-existing heart disease and 7 from respiratory disease. Alcohol and drug use featured prominently in a si2nificant no. of cases. In 27 cases public drunkenness was classified as the most serious offence leading to the detention. 9 deaths were associated with dan2erous alcohol and drug use.

[5] National Aboriginal Health Strategy Working Party (1989) A National Abori2inal Health Strategy: Report of the National Aboriginal Health Strategy Working Party. The NAHS was a joint Common~wealth/ State! Territory strategy which focused on pubic health infrastructure for ATSI communities and which aims to provide equity of access to health services and facilities for ATSI people by 2001. The role of Aboriginal health workers is discussed in depth in the report as a key feature of improvements in ATSI health.

[6] ATSIC 1994 The National Aboriginal Health Strategy: An Evaluation.

[7] R. Murray 'The New Paternalism in Aboriginal Affairs' *The Australian* 14 June 1995.

[8] Some recent sources of information include: -1992 National Housing and Community Infrastructure Needs Survey (commissioned by ATSIC) -Australian Institute of Health and Welfare (AIHW) health related data collection
-National Aboriginal and Torres Strait Islander Survey (NATSIS) 1994 (ABS nationwide survey') . social, demographic, health and economic information on indigenous peoples.(initial results released April 1995), -1994 Dept of Human Services and Health survey of drug use among Aboriginal and Torres Strait Islander peoples to be available June 1995.

[9] I. Tregenza and K.Abbot (1995) *Rhetoric and* Reality *Perceptions of the Roles of Aboriginal Health Workers in Central Anstralia.* Central Australian Aboriginal Congress.

[10] B.Flick "Aboriginal Health Workers: Slaves or Miracle Workers?" in AIHWJ 19(3) May/June 1995 .p. 10.

[11] Interviews carried out with health workers within the Faculty of Health Sciences during 1995. National Priorty Reserve Fund Project.

[12] B.Flick ~Aboriginal Health Workers: Slaves or Miracle Workers 2' in AIHWJ 19(3) May/June 1995 .p. 10.

[13] Mitchell. D. (1994) et al

[14] V.Arbon. M.Nugent & D.Mitchell. 1993-4.

[15] Nugent. M.. PartlinJ. & Farrington. S. (1992) Adult Education Principles to Access Aboriginal Students to Tertiary Education. Paper presented at the Australian Council for Adult Literary: Nu gent. M.& Arbon. V. (1994) More than an Accessory: A Critical Approach to Aboriginal Access Programs. Paper presented at Access Network Conference. Univ. of Southern Maine. Maine USA.

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